MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address Texas Imaging & Diagnostic Center 3840 W. Northwest Highway, Ste. 400 Dallas, TX 75220	MDR Tracking No.: M4-03-6915-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Pacific Employers Insurance Co. Box 15	Date of Injury: Employer's Name: Insurance Carrier's No.: C135C5896715

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
06/04/02	**06/04/02**	**76000-WP**	**$110.00**	**$110.00**
06/04/02	**06/04/02**	**A4644**	**$150.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated April 28, 2003 states in part, "…We were not reimbursed properly for CPT Codes 76000 amd A4644. I have submitted this claim with a copy of the TWCC Fee Guidelines and the carrier has not reimbursed us…"

PART IV: RESPONDENT'S POSITION SUMMARY

A Position Summary was not submitted by the respondent; however, adjustor noted on the TWCC-60 response that states, "Carrier stands on the reduction of 76000 as per TWCC fee guideline this procedure is global to the primary procedure. However, re-audit has found that there was an error in the reduction of !4644 and a check for $127.50 has been issued."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 76000-WP for date of service 06/04/02 denied as "G – Unbundling". Fluoroscopy is not considered global to the primary procedure per TWCC Advisory 97-01. Per the Advisory the requestor has submitted convincing evidence of the procedure in the submitted report to support services were rendered as billed. Reimbursement in the amount of $110.00 is recommended.

- HCPCS A4644 for date of service 06/04/02. The carrier made a supplemental payment of $127.50 leaving a balance of $22.50. Per Rule 133.1(a)(8) the requestor has not submitted convincing evidence to support $150.00 is their fair and reasonable amount for reimbursement and that an additional reimbursement of $22.50 is warranted. Additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
6/4/2002	76000-WP	$110.00	$110.00				
	A4644	$22.50	$0.00				
					Total Left Column:		$132.50
					Total Amount Due:		$110.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $110.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster	01/13/05
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____